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No.

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

KIP HAYES,
Petitioner,

vs.

PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, et al.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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EDITOR'S NOTE

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QUESTIONS PRESENTED

This action involves a medical insurance contract covering petitioner pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. Section 8901, *et seq.* ("FEHBA"). Section 8902(m)(1) of FEHBA provides:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

The United States Court of Appeals for the Ninth Circuit, based solely upon Section 8902(m)(1), held that petitioner could not maintain an action under California law against private insurance carriers to enforce petitioner's rights under a FEHBA medical insurance plan.

The questions presented are:

1. Whether FEHBA contains a comprehensive civil enforcement scheme intended by Congress to both displace and supplant state laws designed to regulate private insurers—that is, does FEHBA provide a superseding federal remedy that will accomplish the express purpose of FEHBA to provide federal employees with health insurance benefits co-extensive with those available to the private sector, at the lowest possible cost.

2. Whether petitioner's state law claims against private insurance carriers to enforce his rights to receive benefits under FEHBA are inconsistent with Section 8902(m)(1).

3. Whether the dispute between petitioner and respondents, private insurance carriers, is a private controversy, in which the federal government simply does not have an interest sufficient to justify federal court jurisdiction.

LIST OF PARTIES

The parties to the proceedings below were petitioner, KIP HAYES, and respondents, PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, and petitioner's father, NOBEL A. HAYES.

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No. _____

IN THE

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October Term 1987

KIP HAYES,
Petitioner,

vs.

PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, et al.,
Respondents.

PETITION FOR WRIT OF CERTIORARI

Petitioner, KIP HAYES, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit, entered in the above-entitled proceeding on June 15, 1987.

OPINIONS BELOW

The order of the United States District Court, Southern District of California (Nielsen, L.C.) granting respondents' motion for summary judgment has not been reported. It is re-printed in Appendix "A," attached hereto.

The opinion of the United States Court of Appeals for the Ninth Circuit affirming the district court's order granting respondents' motion for summary judgment is reported at 819 F.2d 921 (9th Cir. 1987), and is re-printed in Appendix "B," attached hereto.

The order of the United States Court of Appeals for the Ninth Circuit denying petitioner's petition for rehearing in the Ninth Circuit Court of Appeals, is reprinted in Appendix "C," attached hereto.

JURISDICTION

Petitioner originally brought this action in the Superior Court of California, County of San Diego, on April 16, 1984. Thereafter, respondent NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES removed the action to the United States District Court, for the Southern District of California, alleging federal jurisdiction under 28 U.S.C. §§1331, 1332(a) and 1441.

Thereafter, respondents brought a motion for summary judgment seeking an order dismissing petitioner's state law claims on the grounds said claims were preempted by §8902(m)(1) of FEHBA. Said motion was granted by the district court on January 14, 1985.

Thereafter, petitioner filed a timely appeal to the Ninth Circuit Court of Appeals. On June 15, 1987, the Ninth Circuit Court of Appeals issued an order affirming the district court's order. A petition for rehearing was timely sought and subsequently denied on July 21, 1987.

On October 2, 1987, Justice O'Connor ordered that the time for filing the petition for a writ of certiorari be extended to and including November 18, 1987.

The jurisdiction of this court to review the judgment of the Ninth Circuit is invoked under 28 U.S.C. §1254(1).

STATUTES INVOLVED

The Federal Employees Health Benefits Act of 1959, 5 U.S.C. §§8901-8913. The entire Federal Employees Health Benefits Act ("FEHBA") is re-printed in Appendix "D," attached hereto.

STATEMENT OF THE CASE

Petitioner initiated this action in the Superior Court for the State of California, County of San Diego, alleging, *inter alia*, that respondents PRUDENTIAL INSURANCE COMPANY OF AMERICA ("PRUDENTIAL") and NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES ("NLP")[1] tortiously breached the insuring provisions of the POSTMASTERS BENEFIT PLAN (the "PLAN"), an "employee organization" medical insurance plan issued by NLP and underwritten by PRUDENTIAL. Petitioner alleged, *inter alia*, that NLP and PRUDENTIAL conspired to unreasonably deny health insurance benefits to petitioner, payment of which had been requested by the UNITED STATES OFFICE OF PERSONNEL MANAGEMENT ("OPM") pursuant to the administrative liberalization provisions of FEHBA. OPM's request was based upon its findings that payment of said benefits was in the best interests of the United States government, federal employees, and the carriers themselves. In addition, petitioner's complaint set forth separate and distinct allegations of nonpayment and delays in payment of other separate and unrelated claims.

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[1] The NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES is a nonprofit corporation principally conducting business as a "carrier" under the Federal Employees Health Benefits program.

On April 15, 1984, NLP petitioned for removal to the United States District Court for the Southern District of California alleging jurisdiction under 28 U.S.C. §§1331, 1332(a) and 1441, on the grounds of: (1) complete diversity of citizenship; and (2) federal question jurisdiction. NLP's petition alleged that the POSTMASTERS BENEFIT PLAN is a government procurement contract governed by federal law, and the district court had original jurisdiction over petitioner's action because petitioner's state law claims were preempted pursuant to 5 U.S.C. §§8912 and 8902(m)(1).

Respondents PRUDENTIAL and NLP subsequently moved for summary judgment seeking an order dismissing petitioner's state law claims on the grounds that said claims were preempted by §8902(m)(1) of FEHBA. The district court granted respondents' motion, and petitioner filed a timely appeal to the Ninth Circuit Court of Appeals.[2]

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[2] As set forth at pp. 10-13, *infra*, prior to petitioner initiating his state court action, NLP had filed a declaratory relief action in the United States District Court for the Southern District of California naming OPM as a defendant and seeking a judicial declaration that respondents could lawfully disregard OPM's findings and requests made pursuant thereto. Thereafter, based upon NLP's filing of a NOTICE OF RELATED CASE, petitioner's action was consolidated with the action brought by NLP against OPM, and both cases were heard by the Honorable Leland C. Nielsen, District Judge.

Thereafter, on motions for summary judgment, the district court found against OPM in the declaratory relief action initiated by NLP, and dismissed petitioner's action as being preempted by FEHBA. Both actions were subsequently appealed to the Ninth Circuit Court of Appeals. Due to the related nature of the two actions, separate and complete records were not prepared for each action presented to the Ninth Circuit of Appeals. Thus, facts set forth in the instant petition are supported by the excerpts of record submitted in both consolidated cases, *National League of Postmasters of the United States v. United States of Personnel Management, et al.*, District Court Case No. 84-

A. Overview Of FEHBA.

In 1959, Congress enacted the Federal Employees Health Benefits Act, 5 U.S.C. §8901, *et seq.*, which created a subsidized health insurance system for federal employees. The government's subsidy is set at 60% of the average subscription costs of the six largest plans. 5 U.S.C. §8906. Employees pay the balance of the premiums due on the particular plan they select.

Congress expressly enacted FEHBA to provide "a measure of protection for civilian government employees against the high, unbudgetable, and, therefore, financially burdensome costs of medical services through a comprehensive Government-wide program of insurance for Federal employees and their dependents . . . ." 1959 *U.S. Code Cong. & Ad. News*, legislative history, 2914. At the time FEHBA was enacted, Congress recognized that "a wide gap" existed between the Government, in its capacity of employer, and employers in private enterprise, with respect to health benefits for employees. *Id.* at 2914. Thus, FEHBA was designed to close the gap between health insurance benefits available in the private sector and those available to federal employees, therefore making the federal government more competitive in the recruitment and retention of competent civilian personnel. *Id.* at 2914.

FEHBA is designed to be competitive, with numerous private insurance carriers acting as underwriters. Insurers may offer four types of coverage including: (1) a government-wide "service benefit plan"; (2) a government-wide "indemnity benefit plan"; (3) "employee organization

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0341 LCN, Court of Appeal Case No. 85-5528, and *Kip Hayes v. Prudential Insurance Company of America, et al.*, District Court Case No. 84-1245, Court of Appeal Case No. 85-5527.

plans"; and (4) "comprehensive medical plans." 5 U.S.C. §8903. The instant action involves an "employee organization plan" with NLP acting as the "carrier" and PRUDENTIAL acting as the "underwriter."

The UNITED STATES OFFICE OF PERSONNEL MANAGEMENT ("OPM") is responsible, under FEHBA §8902(a), for negotiating and approving the terms of "employee organization plans" such as the one offered by respondents. The benefits under all FEHBA contracts are subject to "such maximums, limitations [and] exclusions . . . as [OPM] considers necessary or desirable." 5 U.S.C. §8902(d). OPM assumes the obligation of considering costs to federal employees and the government in approving and/or modifying health benefit plans. FEHBA specifically delegates administrative responsibilities to OPM to ensure maximum health benefits for federal employees at the lowest possible cost to the employees and the United States government. *Doe v. Divine*, 703 F.2d 1319 (D.C. Cir. 1983).

Essentially, OPM, as the governmental agency authorized to administer public funds on behalf of FEHBA plan participants, is charged with the duty of performing that function in the best interest of both the employees and the United States government.[3]

FEHBA confers express authority upon OPM to attain the goals and objectives underlying the act. 5 U.S.C. §8909(b)(2) provides that OPM shall set aside a fund "not to exceed 3% of the contributions toward the plan, determined by the Office to be reasonably adequate to

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[3] In *Doe v. Divine*, 703 F.2d 1319 (D.C. Cir. 1983), and *National Federation of Federal Employees v. Divine*, 679 F.2d 907 (D.C. Cir. 1981), the United States Court of Appeals, District of Columbia Circuit, provides a more complete "overview of FEHBA," as well as an in-depth analysis of OPM's duties with respect to the administration of the FEHBA program.

provide a contingency reserve." 5 U.S.C. §8909(b)(2) further provides that "the contingency reserves may be used . . . to increase the benefits provided by, the plan from which the reserves are derived, as the Office from time to time shall determine."

5 U.S.C. §8913 provides OPM with authority to prescribe regulations necessary to carry out the provisions of the act. Pursuant to that legislative directive, OPM has promulgated regulations set forth in 5 C.F.R. §890. Section 890.503(c)(5) of OPM's regulations provides:

> In addition to those amounts, if any, paid under the above subparagraphs of this paragraph, OPM may authorize such other payments from the contingency reserve as, in the judgment of OPM may be in the best interest of employees and annuitants enrolled in the program.

B. Petitioner's Claim For Nursing Care Benefits.

Petitioner is eligible for coverage under the PLAN as a dependent of his father, a retired federal employee and member of the PLAN. Petitioner's coverage became effective under the PLAN on January 1, 1982.

Since 1974, petitioner has been a respirator-dependent quadriplegic as a result of a spinal cord injury sustained in a high school football game. Petitioner's spinal cord injury was so severe that he was hospitalized for two years and was released from the hospital only upon condition that he receive 24-hour private duty nursing care. During calendar years 1982 and 1983, petitioner received approximately $170,000 per year in private duty nursing care insurance benefits under the PLAN. It is undisputed that if petitioner did not receive these nursing care benefits, the only mode of care compatible with continued preservation of his life

would be confinement in an acute hospital care facility. It is also undisputed that acute hospital care would cost the PLAN approximately twice as much as the 24-hour nursing care.

Effective January 1, 1983, the PLAN was modified to limit private duty nursing care benefits to a maximum of $10,000 per year.[4] Hospitalization benefits, however, remained unlimited.

C. Pursuant To The Request And Direction Of OPM, The PLAN Was Liberalized In 1983 To Provide Petitioner With Unlimited Private Duty Nursing Care Benefits From The Plan's Contingency Reserve Fund Based Upon OPM's Determination That Said Payments Were In The Best Interest Of The Plan.

Recognizing its duty to preserve and further the economic interests of the United States government, the PLAN, and federal employees, OPM engaged in a comprehensive investigation and analysis aimed at determining whether or not implementation of the $10,000 nursing care limitation would be cost-effective as to petitioner. OPM's investigation included consideration of specific economic and technical factors including, but not limited to:

a. A detailed examination of the specific nursing care provided to petitioner and the extent to which said nursing care was medically necessary;

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[4] The terms of the NLP PLAN are renegotiated each year. In 1982, the PLAN provided "unlimited" benefits for private duty nursing care.

b. A determination as to whether alternative care was available through local or state government medical care programs;

c. The cost of alternative care in an acute hospital confinement facility; and

d. The extent to which confinement in an acute hospital care facility would endanger petitioner's health and interfere with the continued enjoyment of his life.

Based upon their investigation, OPM determined that petitioner would be contractually entitled to receive acute hospital confinement care benefits and that those benefits would cost the United States government, the PLAN, and federal employees approximately *twice* as much as continued payment of nursing care benefits.

Based upon OPM's determination that hospital confinement benefits would cost the PLAN twice as much as nursing care benefits, OPM requested and directed NLP to remove the $10,000 limitation for private duty nursing care from the PLAN for contract year 1983. On January 6, 1983, after considering the request and direction from OPM, NLP's board of directors[5] agreed to liberalize the PLAN and remove the $10,000 nursing care limitation as to petitioner, on condition that OPM authorize a special contingency reserve payment to NLP pursuant to OPM's authority under 5 C.F.R. 890.503(c)(5).

Thus, petitioner received unlimited nursing care benefits during calendar year 1983.[6] Thereafter, the $10,000 limitation on private duty nursing care benefits remained in

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[5] It is undisputed that the only individuals with authority at NLP or PRUDENTIAL to approve OPM's request, was the NLP Board of Directors.

[6] Respondents were reimbursed for these payments from the PLAN's contingency reserve fund.

the PLAN for calendar year 1984, and OPM once again requested that NLP remove the $10,000 limitation as to petitioner, based upon the aforementioned specific economic considerations which had remained unchanged.

D. NLP And PRUDENTIAL Refused To Comply With OPM's Request To Provide Petitioner With Unlimited Private Duty Nursing Care Benefits For Calendar Year 1984, Despite OPM's Determination That Said Payments Were In The Best Interests Of The PLAN, The United States Government, And Federal Employees.

On September 28, 1983, while negotiations were being conducted between OPM and NLP regarding the terms of the 1984 PLAN, Kevin J. Burns, Assistant Director of Insurance Programs at OPM, telephoned Mr. Keith Micheli, PLAN Administrator at NLP,[7] to request that NLP renew its agreement to provide petitioner with unlimited private duty nursing care benefits for contract year 1984. Mr. Micheli thereafter informed NLP's President, R. Fain Hambright, of Mr. Burns' request in a memo dated September 28, 1983.

On October 27, 1983, Mr. Burns wrote directly to NLP's President, Mr. Hambright, informing him that OPM had determined that it would be in the best interests of the FEHBA program to continue providing petitioner with private duty nursing care for calendar year 1984.

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[7] Although Mr. Micheli was the PLAN administrator for NLP, he was also a full-time paid employee of PRUDENTIAL. Mr. Micheli's dual capacity with NLP and PRUDENTIAL reflects the true nature of the identity of interests between NLP and PRUDENTIAL.

On November 15, 1983, approximately two and one-half months before the NLP Board of Directors voted on whether or not to accede to OPM's request to provide petitioner with unlimited private duty nursing care benefits for 1984, Mr. Ken Michler, Senior Claim Consultant at PRUDENTIAL, informed all PRUDENTIAL claims individuals involved with the NLP PLAN, that petitioner would not receive private duty nursing care benefits in excess of $10,000 for calendar year 1984.

Despite PRUDENTIAL's pre-determination that petitioner would not receive nursing care benefits in excess of $10,000, on December 29, 1983, OPM advised petitioner that OPM had not withdrawn its request that NLP provide petitioner with unlimited nursing care benefits for contract year 1984.

On February 6, 1984, the NLP Board of Directors met. Although no one from OPM was present, PRUDENTIAL's Vice-President, John Adelham, and employees Keith Micheli, and C. L. Fritz attended the meeting. During the meeting, Mr. Harvey Moritz, Vice-President of NLP, moved to liberalize the 1984 PLAN and provide petitioner with unlimited nursing care benefits to the same extent those benefits were provided during calendar year 1983, *on condition that OPM approve a modification of the 1984 PLAN*. The NLP Board of Directors were never advised that OPM had already requested such a modification! This was despite the presence of PRUDENTIAL employee Keith Micheli, and NLP President, Fain Hambright, both of whom had personally received communications from OPM indicating such a request.

Mr. Moritz' motion failed, on a five-to-four vote.[8] After the motion failed, another NLP Board member, Mr.

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[8] The NLP Board of Directors consists of nine members.

Victoria, moved to initiate a lawsuit against petitioner seeking a judicial declaration that the $10,000 nursing care limitation could lawfully be enforced against petitioner for 1984.

Thereafter, on February 13, 1984, NLP filed a declaratory relief action in the United States District Court for the Southern District of California, seeking a judicial declaration that the $10,000 nursing care limitation could be lawfully enforced against petitioner. This action was filed despite OPM's uncontradicted determination that providing petitioner with unlimited nursing care benefits from the PLAN's contingency reserve fund was in the best interests of the PLAN, the Federal Government, and Federal employees.[9]

In the declaratory relief action, NLP, as the only plaintiff, named as defendants only OPM and petitioner's father, Nobel Hayes. NLP then brought a motion for summary judgment seeking a judicial declaration that NLP was not obligated to pay claims for benefits in excess of $10,000 for private duty nursing care services rendered to petitioner during calendar year 1984.

Thereafter, petitioner moved, pursuant to Rule 19 of the Federal Rules of Civil Procedure, that he be joined as a defendant in the declaratory relief action brought by NLP

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[9] Petitioner has been able to discern only a single motive for NLP and PRUDENTIAL's refusal to comply with OPM's request. Under the FEHBA program, carriers have a financial incentive to pay, not deny, claims, because the allocation of administrative expense funds is determined on an historical claims-paid basis. (Oversight hearing on the Federal Employee Health Benefits Program—Health Care Costs: Hearings Before the Subcomm. on Compensation and Employee Benefits of the Com. on Post Office and Civil Service, 95th Cong., 1st Sess., p. 11, 55-56 (1977).) Thus, NLP and PRUDENTIAL will receive a higher allocation of administrative expense funds if petitioner receives more benefits for acute hospital care than private duty nursing care.

against OPM, and submitted a memorandum of points and authorities in opposition to NLP's motion for summary judgment.[10]

The district court granted NLP's motion for summary judgment, holding that NLP was not required to provide petitioner with private duty nursing care benefits in excess of $10,000 during calendar year 1984.

Petitioner appealed the district court's ruling on NLP's declaratory relief action, arguing that 5 U.S.C. §8909(b)(2) grants OPM the authority to compel a carrier's concurrence regarding expenditures from the contingency reserve fund when such actions are in the best interests of the PLAN.[11] OPM did not appeal the district court's adverse ruling but, instead, filed a brief with the Ninth Circuit Court of Appeals indicating that OPM interpreted §8909(b)(2) as requiring the carrier's voluntary assent to any liberalization of the PLAN. After considering petitioner's argument, the Ninth Circuit Court of Appeals concurred with OPM's interpretation. (819 F.2d 921 (9th Cir. 1987.))

E. Petitioner's Claims Under California State Law.

On April 16, 1984, petitioner filed his state court action in response to NLP's declaratory relief action.[12]

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[10] The district court never issued a ruling on petitioner's motion to be joined as a defendant in the action brought by NLP against OPM. The court did, however, accept for filing petitioner's points and authorities.

[11] The Ninth Circuit Court of Appeals noted that the district court did not rule on petitioner's motion to be joined as a defendant in the *NLP v. OPM* action; however, the Ninth Circuit specifically found that petitioner's appeal of the district court's order was effective. *Hayes v. Prudential*, 819 F.2d 921, 924 (9th Cir. 1987); p. B-7, *infra*.

[12] Petitioner stated the following causes of action: 1. Breach of Contract; 2. Declaratory Relief; 3. Breach of the Duty of Good Faith

Petitioner's state claims included allegations that NLP and PRUDENTIAL breached California's implied covenant of good faith and fair dealing by unreasonably refusing to comply with OPM's request.[13] *Petitioner further alleged that NLP and PRUDENTIAL delayed and failed to make benefit payments to petitioner which were separate and distinct from OPM's request for liberalization*[14]

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and Fair Dealing; 4. Breach of the Statutory Duties under California Insurance Code §790.03 (West's 1982); 5. Civil Conspiracy to Breach the Implied Covenant of Good Faith and Fair Dealing and to Violate California Insurance Code §790.03; 6. Common Law Fraud; and 7. Breach of Fiduciary Duty.

[13] Although OPM does not have authority under FEHBA to compel private insurance carriers such as NLP and PRUDENTIAL to liberalize their plans and receive payments from the contingency reserve fund, the implied covenant of good faith and fair dealing under California law provides a clear remedial mechanism for effectuating the express purposes of Congress—to provide Federal employees with the best possible medical insurance at the lowest possible cost. Under California law, the implied covenant of good faith and fair dealing "requires that neither party will do anything to injure the right of the other to receive the benefits of the agreement, and *an insurer is obligated to give the interests of the insured at least as much consideration as it gives its own interests.* [Emphasis added.] *Silberg v. California Life Insurance Co.*, 11 Cal.3d 452, 460 (1974). More recently, in *McCormick v. Sentinel Life Insurance Co.*, 153 Cal.App.3d 1030 (1984), the court pointed out that the "duty of good faith and fair dealing requires an insurer to place the interests of the insured above its own or its stockholders' interest[s] in maximizing gains and limiting disbursements." *Id.* at 1043. Clearly, NLP and PRUDENTIAL's decision to maximize their own administrative expense receipts, by refusing to comply with OPM's request designed to minimize costs to Federal employees and the government, constitutes a *per se* violation of the implied covenant of good faith and fair dealing as it exists under California law.

[14] Although it is undisputed that petitioner is entitled to additional nursing care benefits which have not been paid, the Ninth Circuit's decision precludes petitioner from bringing an action under California law to compel payment, while at the same time, FEHBA does not

As set forth above, the district court ultimately dismissed plaintiff's state court causes of action, holding they were preempted by §8902(m)(1) of FEHBA. The district court's order was affirmed by the Ninth Circuit Court of Appeals, giving rise to the instant Petition for Certiorari.

REASONS FOR GRANTING THE WRIT

I

THE NINTH CIRCUIT'S DECISION THAT PETITIONER'S STATE LAW CAUSES OF ACTION ARE "PREEMPTED" BY §8902 (m)(1) IS IN DIRECT CONFLICT WITH A DECISION FROM THE TENTH CIRCUIT COURT OF APPEALS

In his briefs to the Ninth Circuit Court of Appeals, petitioner, citing substantial legislative history, argued that §8902(m)(1) was intended by Congress to be a statute of "limited preemption" not intended to displace *and* supplant all state law regulating insurers under FEHBA. Petitioner further relied upon the holding in *Howard v. Group Hospital Service*, 739 F.2d 1508 (10th Cir. 1984) in support of his argument that FEHBA, in and of itself, does not provide FEHBA participants with a sufficient remedy to enforce individual claims for payment of benefits.

In holding that petitioner's state law claims were completely preempted by §8902(m)(1), the Ninth Circuit acknowledged that its decision was not in agreement with the Tenth Circuit's holding in *Howard. Hayes*, 819 F.2d at

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provide any remedial mechanism to compel the carriers to pay. (See discussion of *Howard v. Group Hosp. Service*, 739 F.2d 1508 (10th Cir. 1984) at pp. 15-20, *infra*.)

926, p. B-12, *infra*. Instead, the Ninth Circuit, without discussing the legislative history of §8902(m)(1) or its own decision that OPM was powerless to require respondents to act in the best interests of federal employees and the PLAN, cited such cases as *Blue Cross and Blue Shield of Florida, Inc. v. Department of Banking & Finance*, 791 F.2d 1501 (11th Cir. 1986), *Myers v. United States*, 767 F.2d 1072 (4th Cir. 1985), and *Tackitt v. Prudential Insurance Co.*, 758 F.2d 1572 (11th Cir. 1985), none of which address the legislative history of §8902(m)(1) or the distinct lack of remedies available to FEHBA plan participants under federal law.

The Ninth Circuit does not take issue with the Tenth Circuit's reasoning in *Howard*, nor does the Ninth Circuit's opinion address 5 C.F.R. §890.107, relied upon by the Tenth Circuit in support of its conclusion that claims for recovery under FEHBA plans should not involve the federal government, but should be individual actions brought directly against the health benefit insurers. *Howard*, 739 F.2d at 1511.

Unlike the cases interpreting §8902(m)(1) relied upon by the Ninth Circuit in its opinion below, the *Howard* court sets forth a thoughtful and well-reasoned basis for concluding that §8902(m)(1) does not preempt state law actions for recovery on individual claims under FEHBA insurance plans.

In *Howard*, the Tenth Circuit pointed out that FEHBA does not contain a procedural mechanism designed to provide a means of adjudicating individual claims:

> There is no adversarial process set up within the OPM to litigate these claims. Under 5 C.F.R. §890.105(b), the carrier initially determines whether a claim is covered under the policy, and if a claim is denied, 5 C.F.R. §890.106(c) permits a

claimant to 'make a written request to OPM's Associate Director for Compensation for a review to determine whether the plan's denial is in accord with the terms of OPM's contract with the carrier of the plan,' and 5 USC §8902(j) permits the OPM to require the carrier to pay. This review procedure apparently is designed to permit OPM to resolve major conflicts between itself and the carrier over interpretation of the plan. The regulations specifically declare that 'OPM does not adjudicate individual claims for payment or service under health benefit plans.' 5 C.F.R. §890.105(a). Under a section titled, 'Legal Actions' the implementing regulations for the FEP program state, 'An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan.' 5 C.F.R. §890.107.[15] *This contemplates that claims for recovery under the plans should not involve the*

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[15] At the time *Howard* was decided, 5 C.F.R. §890.107 provided:

> An action to compel enrollment of an employee or annuitant not excluded by §890.102(c) should be brought against the employing office. An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan. An action to review the legality of OPM's regulations or a decision made by OPM should be brought against the Office of Personnel Management, Washington, D.C. 20415.

After *Howard* was decided OPM amended §890.107 to further clarify what type of actions *must* be brought against the carrier. §890.107 was amended, May 21, 1986, to add the following:

> However, an enrollee's dispute of an OPM decision solely because it concurs in a health plan carrier's denial of a claim is not a challenge to the legality of OPM's decision. Therefore, any subsequent litigation to recover on the claim should be brought against the carrier, not against OPM.

> *federal government, but should be individual actions against the health benefit carrier.* (Emphasis added.)

Id. at 1511.

The *Howard* court went on to cite with approval, *Director, Edward J. Meyer Memorial Hospital v. Stetz*, 433 F.Supp. 323 (W.D.N.Y. 1977). In *Stetz*, the Civil Service Commission (now OPM) expressed its desire not to be involved in the adjudication of claims for individual benefits.[16] Basing its decision upon OPM's express desire not to be involved in the adjudication of individual claims, the *Stetz* court specifically found that actions to enforce individual claims under FEHBA programs are specifically authorized *only* against the carrier. *Id.* at 325. The court thereafter remanded the action to state court, concluding that federal question jurisdiction did not exist, and finding that "the *sole* recourse for the Stetzes is against the carrier under the statutory scheme." *Id.* at 326 (Emphasis added).

The *Howard* court, after reviewing the decisions in *Clearfield Trust Co. v. United States*, 318 U.S. 363, 63 S.Ct. 573, 87 L.Ed. 838 (1943) and *Miree v. DeKalb County*, 433 U.S. 25, 97 S.Ct. 2490, 53 L.Ed.2d 557 (1977), decided that

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[16] The Civil Service Commission, predecessor to OPM, has long recognized that the states have authority to regulate and tax FEHBA insurance carriers. The Civil Service Commission and OPM have always taken the position that FEHBA was not designed to regulate the insurance business or to override any state regulatory scheme and that no legal basis existed for it to issue a regulation restricting the applicability of state law to FEHBA contracts. For example, the Deputy General Counsel for the Civil Service Commission reported to a U. S. House Subcommittee: "It is recommended that the Civil Service Commission take appropriate action to inform carriers that the fact that they are administering a federal contract is no reason for circumventing compliance with applicable state laws." Report of the Comptroller General of the United States, MWD 76-49, p. 16, October 17, 1975.

various state court adjudications of individual FEHBA benefit claims would not frustrate the operation of the act or conflict with any specific national policy. *Howard*, 739 F.2d at 1509-1511.

The Tenth Circuit's reasoning in *Howard* is equally, if not more, applicable to the facts of the instant case. Without the application of state law in the instant case, petitioner, OPM, and all federal FEHBA plan participants would be left without any remedial scheme that could effectuate the express Congressional purpose of providing federal employees with medical insurance benefits at the lowest possible cost to the government and to the employees. Application of California state law to petitioner's individual claim for benefits will not frustrate the operation of FEHBA, but will assist in accomplishing the express purposes of the Act.

Finally, the *Howard* court, citing *Railsback v. United States*, 181 F.Supp. 765 (D.Neb.1960), specifically held that individual claims for benefits under FEHBA are purely private controversies in which the federal government simply does not have an interest sufficient to justify invoking federal question jurisdiction. *Howard*, 739 F.2d. at 512. *Railsback* involved a claim brought under a federal group life insurance policy negotiated by the Civil Service Commission (now OPM), a situation not unlike that presented by the instant action. The Tenth Circuit agreed with the following passage from *Railsback*:

> In negotiating for and procuring a policy of group life insurance for its employees, the United States government acts as an agent and not as the insurer. There is no policy of insurance between the government and the employee. It is clear from a reading of the Act that an employee is insured under a policy purchased by the Civil Service Commission, and not under any contract with or

> obligation of the United States. The decedent here was insured under a policy with Metropolitan.
>
> * * *
>
> Under the facts in this case and the Act in question, this Court concludes that the plaintiff has no claim against the United States upon which relief can be granted, and that the United States has not consented to a suit against itself for the claim here made.
>
> The plaintiff here is not without remedy. She may yet proceed in the State Courts in order that her claim might be litigated. There is, however, no jurisdiction in this or any other federal court upon her claim.

Howard, 739 F.2d at 1512, quoting *Railsback v. United States*, 181 F.Supp. 765, 766-67 (D. Neb. 1960).

The Ninth Circuit's decision in the instant action is directly in conflict with the thoughtful and well-reasoned decision of the Tenth Circuit in *Howard*. As *Howard* indicates, federal employees have no remedy for the adjudication of individual claims under FEHBA and, in fact, OPM's implementing regulations require that individual claims for recovery of benefits be brought directly against the insurance carriers. This court's plenary consideration of the instant action is essential in order to provide clarification to the millions of federal employees insured under FEHBA benefit plans.

II

THE NINTH CIRCUIT'S OPINION IS WHOLLY CONTRARY TO PRINCIPLES OF PREEMPTION ESTABLISHED BY THIS COURT

In a recent line of cases, ending with *Pilot Life Insurance Co. v. Dedeaux*, ___ U.S. ___ , 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987), this court has made it clear that areas of state law traditionally left to regulation by the states are not preempted by federal law unless the federal law both displaces *and* supplants state law—that is, when the federal law provides a superseding remedy replacing and preempting state law. This court has long held that "whether a certain state action is pre-empted is one of congressional intent. 'The purpose of Congress is the ultimate touchstone.' " *Pilot Life Ins. Co. v. Dedeaux*, at ___ U.S. ___ , 107 S.Ct. 1549, 1552 (1987) citing *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208, 105 S.Ct. 1904, 1909, 85 L.Ed.2d 206 (1985), quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504, 98 S.Ct. 1185, 1189, 55 L.Ed.2d 443 (1978), quoting *Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103, 84 S.Ct. 219, 222, 11 L.Ed. 179 (1963).

Congress has not explicitly stated to what extent §8902(m)(1) is intended to preempt state law.[17] Thus, the

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[17] Petitioner contends that both the specific wording of §8902(m)(1) and the legislative history which preceded its enactment in 1978, make it clear that the provision was never intended to supersede State Laws regulating insurance companies. By its terms, §8902(m)(1) preempts only state laws regarding *coverage or benefits* and then only state laws which are *inconsistent* with the contractual provisions of the FEHBA plan. It does not address petitioner's action against respondents for their wrongful conduct in unreasonably refusing OPM's request to provide benefits. In addition, there is no conflict between §8902(m)(1) and the

courts must sustain petitioner's state action "unless it conflicts with federal law or would frustrate the federal scheme, or unless the courts discern from the totality of the circumstances that Congress sought to occupy the field to the exclusion of the States." *Allis-Chalmers v. Lueck*, 471

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state remedies sought by petitioner.

The legislative history of §8902(m)(1) was enacted after Congress received a report by the Comptroller General of the United States on October 17, 1975. (Report of the Comptroller General of the United States, MWD 76-49, p. 16, October 17, 1975.) The report is entitled, "Conflicts Between State Health Insurance Requirements And Contracts Of The Federal Employee Health Benefits Carriers." This report specifically addresses difficulties arising from state laws requiring medical insurance carriers to provide certain types of benefits. Likewise, a thorough examination of the Senate and House Reports in hearings before Senate and House Subcommittees reveals no mention of any intent by Congress that FEHBA supersede the McCarran-Ferguson Act and preempt all state laws regulating the business of insurance. In fact, even the titles of the bill as they changed going in and out of House and Senate Subcommittees make it clear that Congress intended only a very limited preemption. The 1978 amendment adding §8902(m)(1) was initially recorded by the Congressional Record to read: "an act to amend Chapter 89 of Title 5 of the United States Code to establish uniformity in federal employee health benefits and coverage by preempting state or local laws pertinent to such benefits and coverage which are inconsistent with such contracts." (Congressional Record, Volume 123, part 16, p. 19780 (95th Cong., 1st Sess., June 20, 1977).) The title was thereafter changed to read, "An Act to amend chapter 890 of title 5 of the United States Code to estabish uniformity in federal employee health benefits and coverage by preempting *certain* inconsistent State and local laws which are inconsistent with such contract." (emphasis added.) (Congressional Record, Volume 124, Part 12, p. 16243 (95th Cong., 2nd Sess., June 5, 1978).)

It is inconceivable that Congress intended 5 U.S.C. §8902(m)(1) to entirely emasculate the McCarran-Ferguson Act (15 U.S.C. §1011, *et seq.*) without ever mentioning it, or indeed, without enacting specific federal law designed to supplant state laws currently regulating the business of insurance.

U.S. 202, 209, 105 S.Ct. 1904, 1910, 85 L.Ed.2d 206 (1985), quoting *Malone v. White Motor Corp.*, 435 U.S. at 504, 98 S.Ct. at 1190.

This Court has repeatedly underscored the need to fully analyze legislative intent with respect to the preemption issue. In *Cort v. Ash*, 422 U.S. 66, 78, 45 L.Ed.2d 26, 36, 95 S.Ct. 2080 (1975), this Court set forth the following four-factored analysis to be used in determining whether state law is preempted:

> In determining whether a private remedy is implicit in a statute not expressly providing one, several factors are relevant. First, is the plaintiff 'one of the class for whose *especial* benefit the statute was enacted,' *Texas & Pacific R. Co. v. Rigsby*, 241 U.S. 33, 39, 60 L.Ed 874, 36 S.Ct. 482 (1916) (emphasis supplied)—that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? See, e.g., *National Railroad Passenger Corp. v. National Assn. of Railroad Passengers*, 414 U.S. 453, 458, 460, 38 L.Ed.2d 646, 94 S.Ct. 690 (1974) (Amtrak). Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? See, e.g., *Amtrak, supra; Securities Investor Protection Corp. v. Barbour*, 421 U.S. 412, 423, 44 L.Ed.2d 263, 95 S.Ct. 1733 (1975); *Calhoon v. Harvey*, 379 U.S. 134, 13 L.Ed.2d 190, 85 S.Ct. 292 (1964). And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law? See *Wheeldin v.*

> *Wheeler*, 373 U.S. 647, 652, 10 L.Ed.2d 605, 83 S.Ct. 1441 (1963); cf. *J. I. Case Co. v. Borak*, 377 U.S. 426, 434, 12 L.Ed.2d 423, 84 S.Ct. 1555 (1964); *Bivens v. Six Unknown Federal Narcotics Agents*, 403 U.S. 388, 394-395, 29 L.Ed.2d 619, 91 S.Ct. 1999 (1971); *id.* at 400, 29 L.Ed.2d 619, 91 S.Ct. 1999 (Harlan, J., concurring in judgment).

422 U.S at 78-79.

Applying this four-factor analysis to FEHBA, the only reasonable conclusion is that Congress did not intend that FEHBA preempt petitioner's state law created causes of action. First, FEHBA obviously creates a right in favor of petitioner. Second, there is nothing in FEHBA, or the legislative history of FEHBA, that indicates Congress intended to create a comprehensive civil enforcement mechanism designed to replace and supplant state laws regulating FEHBA insurers. To the contrary, the legislative history establishes that Congress intended §8902(m)(1) to be a statute of "limited" preemption." Third, it would be inconsistent with the underlying purposes of FEHBA to allow respondents to go unregulated and, therefore, expose thousands of federal employees to the unilateral, self-serving decisions of FEHBA insurers in conscious disregard of the welfare of the United States government and federal employees. Finally, the business of insurance has traditionally been regulated by state law. *See* W. Shernoff, S. Gage, & H. Levine, *INSURANCE BAD FAITH LITIGATION*, §§6.01-6.02[6].

Most recently, this Court addressed the preemption issue as it applies to the Employees Retirement Security Act of 1974, 29 U.S.C. §§1001, *et seq.* (ERISA) in *Pilot Life Insurance Co. v. Dedeaux*, ___ U.S. ___, 107 S.Ct. 1549 (1987). In *Pilot Life*, the Court set forth a detailed analysis

of the legislative history of §502(a) of ERISA,[18] finding that Congress intended that §502 be the exclusive remedy for all ERISA plan participants, to the exclusion of any and all state laws. *Id.* __ U.S. at __ , 107 S.Ct. at 1558. This court found that Congress' enactment of a detailed civil enforcement scheme under ERISA clearly reflects Congress' intent that ERISA's civil enforcement scheme be exclusive:

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[18] Section 502(a), as set forth in 29 U.S.C. §1132(a) provides:

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, [concerning requests to the administrator for information]; or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title [breach of fiduciary duty];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title [information to be furnished to participants];

(5) except as otherwise provided in subsection (b) of this subsection, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

The civil enforcement scheme of §502(a) is one of the essential tools for accomplishing the stated purposes of ERISA. The civil enforcement scheme is sandwiched between two other ERISA provisions relevant to enforcement of ERISA and to the processing of a claim for benefits under an employee benefit plan. . . . Under the civil enforcement provisions of §502(a), a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits. Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty, and under this cause of action may seek removal of the fiduciary. §§502(a)(2), 409. In an action under these civil enforcement provisions, the court in its discretion may allow an award of attorney's fees to either party. §502(g). . . .

In sum, the detailed provisions of §502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. 'The six carefully integrated civil enforcement provisions found in

> §502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.'
>
> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.

107 S.Ct. at 1555-1556.

FEHBA, unlike ERISA, does not contain a detailed and comprehensive civil enforcement mechanism. Therefore, petitioner's state law causes of action should not, and *cannot* be preempted by any civil enforcement mechanisms in FEHBA. Certainly, if petitioner had an opportunity to avail himself of a comprehensive civil enforcement scheme, such as the one set forth in §502(a) of ERISA, preemption would appropriately apply to petitioner's state law causes of action. However, a holding that FEHBA preempts state-created remedies deprives petitioner and all federal employees of any remedy to enforce their rights under FEHBA programs.

In the instant action, the Ninth Circuit incorrectly relied upon *Pilot Life*, in holding that petitioner's state causes of action are preempted by FEHBA. In making this determination, the Ninth Circuit clearly violated the well-established principles of preemption set forth by this court in cases such as *Pilot Life*, *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985), *Allis Chalmers Corp. v. Lueck*, 471 U.S. 202, 105 S.Ct. 1904, 85 L.Ed. 206 (1985), and *Cort v. Ash*, 422 U.S. 66, 95 S.Ct. 2080, 45 L.Ed.2d 26 (1975).

III

THE NINTH CIRCUIT'S FINDING OF PREEMPTION IS IN DIRECT CONFLICT WITH OPINIONS ISSUED BY CALIFORNIA COURTS AND RAISES IMPORTANT ISSUES CONCERNING THE RIGHTS OF STATES TO REGULATE THE BUSINESS OF INSURANCE

In *Fields v. Blue Shield of California*, 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (1985), the court specifically found that §8902(m)(1) provides "limited preemption" and does not preclude recovery by FEHBA plan participants against FEHBA insurers based upon California law. *Id.* at 589, 209 Cal.Rptr. at 793. The California Court of Appeals pointed out that counsel for Blue Shield, a FEHBA insurer, "was unable to cite any federal law which would preclude recovery by Dr. Fields on the state action." *Id.*

The California decision in *Fields* is not surprising given the history of state primacy in the field of insurance. In 1945, Congress reestablished the national policy of state primacy in the regulation of insurance by enacting the McCarran-Ferguson Act, 15 U.S.C. §§1012, *et seq.* The McCarran-Ferguson Act provides, in pertinent part:

> Regulation by State law: Federal law relating specifically to insurance, applicability of certain Federal laws after June 30, 1948. (a) *The business of insurance*, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted

> by any State for the purpose of regulating *the business of insurance. . . .*

15 U.S.C. §1012 (1976) (emphasis added).

In *SEC v. National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed. 668 (1969), this Court observed:

> The McCarran-Ferguson Act was an attempt to turn back the clock, to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation.
>
> . . . Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the 'business of insurance' does the statute apply . . . . Congress was concerned with the type of state regulation that centers around the contract of insurance, the transaction which *Paul v. Virginia* [, 8 Wall. 168, 19 L.Ed. 357] held was not 'commerce.' The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement-these were the core of the 'business of insurance.' Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'

Id. at 459-60, 89 S.Ct. at 568.

It is inconceivable that Congress intended FEHBA to supersede the McCarran-Ferguson Act and thereby totally

emasculate the rights of the states to protect and regulate the relationship between its citizens and insurers doing business within those states. The facts of this case establish that Congress did not enact a comprehensive civil enforcement scheme capable of effectuating the express purpose of FEHBA, to provide federal employees with medical insurance benefits at the lowest possible cost. Thus, the only civil enforcement scheme capable of effectuating the express purposes of FEHBA, under the facts of this case, is California state law.

The Ninth Circuit's opinion in the instant action raises serious and important issues concerning the continued rights of states to regulate the business of insurance.

CONCLUSION

For these various reasons, this petition for certiorari should be granted. Petitioner respectfully submits that Congress did not intend that FEHBA completely preempt all state laws regulating insurers under FEHBA plans. To the contrary, the legislative history of FEHBA, as well as the distinct absence of any comprehensive civil enforcement scheme designed to effectuate the express purposes of FEHBA, reflect Congress' intent that §8902(m)(1) be a statute of "limited preemption." The irreconcilable disagreement between the circuit courts on the preemption issue reflects the clear need for resolution of these issues by this Honorable Court.

DATED: November 12, 1987

Respectfully submitted,

Law Offices of
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RICK L. BOVE

APPENDIX "A"

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

FILED, JAN 22, 1985
ENTERED, JAN 23, 1985
Clerk, U.S. District Court
Southern District Of California
By S. Miller Deputy

KIP HAYES, Plaintiff, v. PRUDENTIAL INSURANCE COMPANY, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, and NOBEL A. HAYES, Defendants.	Civil No. 84-1245-N(M) ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

This matter came before this Court on January 14, 1985, for hearing on the motion for summary judgment of defendants Prudential Insurance Company and National League of Postmasters.

Plaintiff Kip Hayes appeared by Harvey R. Levine of Shernoff & Levine. Defendant Prudential Insurance Company appeared by James S. Cline of Adams, Duque & Hazeltine, and defendant National League of Postmasters appeared by John T. Kotelly of Dickstein, Shapiro & Morin. Upon consideration of the arguments of counsel and the moving and opposing papers:

IT IS HEREBY ORDERED that defendants' motion for summary judgment is granted as to all counts of the plaintiff's complaint. This Court concludes as to counts one and two of the complaint that benefits for private duty nursing care have been lawfully reduced to $10,000 per person per year in the 1984 Postmasters Benefit Plan and

that defendants are not obligated to pay claims for private duty nursing benefits in excess of this amount during 1984 nor during any year thereafter so long as the limitation remains. As to the remaining counts in plaintiff's complaint, this Court concludes that these claims under California state laws are preempted under Title V, United States Code section 8902(m)(1).

IT IS SO ORDERED.

Dated: January 22, 1985.

LELAND C. NIELSEN,
United States District Judge

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APPENDIX "B"

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KIP HAYES,
Plaintiff-Appellant,
v.
PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, et al.,
Defendants-Appellees.

Nos. 85-5527;
85-5528
D.C. Nos.
CV-84-1245-LCN
CV-84-0341-LCN
OPINION

Argued and Submitted
November 4, 1985—San Diego, California

Filed June 15, 1987

Before: James R. Browning, Charles Wiggins and Melvin Brunetti, Circuit Judges.

Opinion by Judge Brunetti

Appeal from the United States District Court
for the Southern District of California
Leland C. Nielsen, District Judge, Presiding

SUMMARY

Public Employees

Appeal from two summary judgments. Affirmed.

Appellant Kip Hayes (Kip) is the son of Nobel Hayes (Hayes), a retired federal employee. Kip was injured in a high

school football game and became a respirator-dependent quadriplegic requiring 24-hour private duty nursing care. At the time of the injury Kip was covered as a family member on his father's plan issued under the FEHBA. The plan, administered by Aetna Life Insurance Company, placed no monetary limit on the benefits for private duty nursing care. When the Aetna plan was modified to eliminate such benefits, Hayes enrolled in another FEHBA plan during an open season enrollment period during which changes were permitted. In 1982 Hayes switched to a plan offered by the National League of Postmasters (NLP). In 1983 the NLP was formulated to place a $10,000 limit on benefits for private duty nursing care. The limit was lifted for 1983, but instituted for 1984 and future years.

In February 1984, NLP filed a declaratory relief action in district court naming the Office of Personnel Management (OPM) [which negotiated with NLP regarding the scope of coverage of the plan] and Hayes as defendants. The district court granted summary judgment in favor of NLP on the ground that benefits for private duty nursing care lawfully had been reduced to $10,000 in the 1984 plan. In April 1984 Kip brought an action against NLP in state court arguing that his enrollment in the 1982 plan gave him a vested contractual right to receive, indefinitely, unlimited private duty nursing care benefits. The action was removed to federal district court where the court granted summary judgment in favor of the defendants on the grounds that the benefits lawfully had been reduced, and that the state law claims were preempted under FEHBA.

[1] Although neither Hayes or the OPM appealed the declaratory judgment action in favor of NLP, Kip requested that he be joined as a defendant in that action and the court consolidated the two cases. Kip therefore effectively appealed from the summary judgment in the declaratory relief suit.

[2] An FEHBA provision requiring that a carrier agree to pay in an individual case if OPM finds the family member is

entitled to payment under the terms of the contract does not grant OPM authority unilaterally to alter the terms of the plan, but only requires that the carrier comply with the OPM's interpretation of the plan. OPM's consistently held view is that appellant is not entitled to unlimited benefits under the plan. [3] Appellant also urges that an FEHBA provision providing for a contingency reserve grants OPM authority to compel a carrier to provide benefits beyond those in the negotiated plan. But the OPM's interpretation of the provision as requiring the carrier's concurrence before contingency reserve funds may be used is entitled to substantial deference. [4] Consistent with this view the OPM never invoked authority to direct payment of the additional benefits, and appellant has not challenged OPM's interpretation of its authority. [5] Appellant also contends that the Catastrophic Protection provision of the plan allows the benefits, [6] but this provision only requires payment of 100% of eligible expenses (as opposed to 80%) in some circumstances and does not operate independent of the $10,000 limitation on private nursing care. [7] The limitation on private duty nursing care restricts the eligible expenses subject to the Catastrophic Protection provision.

[8] Appellant's contention that his state law tort and contract claims are not preempted by FEHBA because the claims relate to the manner in which the claim was processed, not to the nature or extent of coverage or benefits, draws a distinction that cannot be made. Tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract. [9] Because the state law claims invariably expand obligations under the terms of the plan, the claims are inconsistent with the plan and preempted by FEHBA. This holding is supported by the Supreme Court's decision that the Employee Retirement Income Security Act preempts state common law tort and contract claims for benefits. To the extent the state law claims are predicated on an alleged obligation to provide benefits in excess of the $10,000 limit the claims are moot.

COUNSEL

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Edward R. Cohen, John T. Kotelly, Ira Mitzner and Elaine Metlin, Washington, D.C.; James S. Cline, Los Angeles, California; R. J. Coughlin, Jr., San Diego, California, for the defendants-appellees.

Phillip S. Neal, Washington, D.C.; James R. Barnett, Washington, D.C., for the amicus curiae.

OPINION

BRUNETTI, Circuit Judge:

This is an appeal from summary judgments granted in two consolidated cases. *Kip Hayes v. Prudential Insurance Co.*, No. 85-5527 (D.C. No. 84-1245), and *National League of Postmasters of the United States v. United States Office of Personnel Management and Nobel Hayes*, No. 85-5528 (D.C. No. 84-0341). We are asked to review the district court's rulings that federal employee health benefits lawfully may be reduced from year to year, and that the Federal Employee Health Benefits Act preempts state law tort and contract actions.

Though we are moved by the compelling circumstances surrounding Kip Hayes and his family, we find that the statute and health benefits plan we are called upon to construe require an unmistakable result. Until Congress acts to ensure continued coverage for federal enrollees who require long-term care, this court will be powerless to provide appellant with the remedy he seeks.

We affirm the district court.

I. THE FEDERAL EMPLOYEE HEALTH BENEFITS ACT

The Federal Employee Health Benefits Act (FEHBA) established a comprehensive program to provide federal employees and retirees with subsidized health care benefits. 5 U.S.C. §§ 8901-8913 (1982 & Supp. 1987). Under the Act, the United States does not act as an insurer, but, through the Office of Personnel Management (OPM), contracts with various private carriers to develop health care plans with varying coverages and costs. The plans are for a term of one year, and are renegotiated annually.

After OPM negotiates changes with the carriers all federal enrollees are permitted to switch enrollment from one plan to another, regardless of their state of health, during a period called "open season." Each enrollee thus may obtain the most beneficial plan but is not guaranteed the same coverage in future years that had been available the preceding year.

The National League of Postmasters (NLP or Postmasters) is a nonprofit corporation and a carrier under FEHBA. Each year, OPM and Postmasters negotiate a contract that determines the benefits Postmasters will provide that year to enrollees in the Postmasters Health Benefits Plan (Plan). The contract between OPM and Postmasters sets forth the precise terms of coverage under the Plan. OPM then issues a Postmasters Benefit Brochure (Brochure) which provides a complete description of the benefits available to enrollees that year.

For several years, Prudential Insurance Company of America (Prudential) has entered into agreements with Postmasters whereby Prudential issues an annual policy to Postmasters which incorporates the terms and conditions of the Brochure as negotiated by Postmasters and OPM for the year. Pursuant to the policy, Prudential administers certain claims presented to Postmasters for payment and, in effect,

guarantees that Postmasters can pay the benefits due enrollees under the Plan.

II. FACTS AND PROCEEDINGS

Appellant Kip Hayes is the son of Nobel Hayes, a retired federal employee. Appellant was injured in a high school football game in November 1976, and was rendered a respirator-dependent quadriplegic requiring 24-hour private duty nursing care. At the time of his injury, appellant was covered as a family member under a FEHBA plan in which his father was enrolled. This plan, administered by Aetna Life Insurance Company, placed no monetary limit on the benefits for private duty nursing care. When the Aetna plan later was modified to eliminate private duty nursing care benefits, Nobel Hayes enrolled during open season in another FEHBA plan that did provide unlimited benefits for private duty nursing care. By 1982, Nobel Hayes again had switched coverage, and enrolled in the plan offered by Postmasters, which at the time had no limits on benefits for private duty nursing care.

In October 1982, following negotiations between OPM and Postmasters, the 1983 Postmasters Plan was formulated to place a $10,000 limit on benefits for private duty nursing care. By subsequent agreement between OPM and Postmasters, the 1983 Plan was amended to remove the $10,000 limit.

The Postmasters Plans for 1984 and 1985 again contained a $10,000 limit on benefits for private duty nursing care. The 1984 and 1985 Plans were not amended and, through the date of the summary judgments in both cases, contained the $10,000 limitation.

In February 1984, Postmasters filed in district court a declaratory relief action naming OPM and Nobel Hayes as defendants. *NLP v. OPM*, D.C. No. CV-84-0341-LCN. Postmasters sought a declaration that private duty nursing care benefits provided under its 1982 Plan could be reduced in

subsequent policy contract years and that under its 1984 Plan Postmasters was not obligated to provide Kip Hayes with private nursing benefits in excess of $10,000.

In April 1984, appellant brought an action against Prudential and Postmasters in the Superior Court for the State of California. The action was removed to federal district court. *Hayes v. Prudential*, D.C. No. CV-84-1245-LCN. Appellant alleged that his enrollment in the 1982 Plan gave him a vested contractual right to receive, indefinitely, unlimited private duty nursing care benefits, and that Postmasters and Prudential had breached the contract by refusing to provide unlimited benefits in 1984. Based on this theory of his rights under the Plan, appellant sought damages alleging various state law causes of action including breach of a duty of good faith and fair dealing, and breach of Cal. Ins. Code § 790.03 (West 1982).

The district court granted summary judgment in favor of Postmasters in *NLP v. OPM* on the ground that benefits for private duty nursing care lawfully had been reduced to $10,000 in the 1984 Postmasters Plan and that Postmasters accordingly was not required to pay claims in excess of that amount.

In *Hayes v. Prudential*, the court granted summary judgment in favor of defendants on the grounds that the benefits lawfully had been reduced, and that the state law claims were preempted under FEHBA, 5 U.S.C. § 8902(m)(1).

III. DISCUSSION

1. *Effective Appeal.*

Postmasters and OPM contend that there has been no effective appeal from *NLP v. OPM*. The basis for this contention is that neither OPM nor Nobel Hayes, the named defen-

dants, have appealed, and the appeal by Kip Hayes is not effective because he was not a party to the action.

[1] A motions panel of this court, however, has determined that Kip Hayes' appeal in *NLP v. OPM* was effective. In his Memorandum of Points and Authorities in Opposition to Motion for Summary Judgment in the *NLP v. OPM* action, appellant requested that the district court join him as a defendant pursuant to Fed. R. Civ. P. 19. The district court treated appellant's request as a motion for consolidation with *Hayes v. Prudential*, and consolidated the cases. Consolidation by the district court led the motions panel to conclude that Kip Hayes effectively appealed from the summary judgment in *NLP v. OPM*.

2. *Standard of Review.*

We review de novo the district court's decision regarding the $10,000 limit on benefits and the preemption of state law claims. *See Darring v. Kincheloe*, 783 F.2d 874, 876, (9th Cir. 1986) (grant of summary judgment is reviewed de novo). Summary judgment is appropriate when there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c).

3. *$10,000 Limit on Nursing Care Benefits.*

Appellant contends that the district court erred in granting summary judgment for appellees because (1) Postmasters and Prudential were required to comply with an OPM directive to provide him unlimited private duty nursing care benefits, and (2) the Plan's Catastrophic Protection provision requires Postmasters and Prudential to provide nursing care benefits without regard to the $10,000 limitation stated elsewhere in the policy.

a) *OPM Directive.*

Appellant cites two sections of FEHBA which he contends grant OPM the authority to require Postmasters and Prudential to provide him with unlimited nursing care benefits.

[2] 5 U.S.C. § 8902(j) provides that "[e]ach contract under this chapter shall require the carrier to agree to pay for or provide a health service . . . in an individual case if [OPM] finds that the . . . family member . . . is entitled thereto under the terms of the contract." This provision does not grant OPM authority unilaterally to alter or amend the terms of the Plan; it requires only that the carrier comply with OPM's interpretation of the Plan. OPM's consistently held view is that, under the Plan's terms, appellant is *not* entitled to unlimited benefits. As a result, Postmasters and Prudential were not required, under section 8902(j), to provide appellant benefits in excess of the $10,000 limit.

Appellant also cites as support 5 U.S.C. § 8909(b)(2). That section states that OPM shall set aside not more than three percent of the payments to each FEHBA plan as a contingency reserve which may be used, among other purposes, to increase the benefits in the plan from which the reserves are derived. The contingency reserve is a resource OPM can use in negotiations with a carrier to expand plan benefits. The availability of such funds was central to the agreement between OPM and Postmasters to remove the $10,000 limit from the 1983 Plan.

[3] Appellant urges that section 8909(b)(2) grants OPM authority to compel a carrier to provide benefits beyond those in the negotiated plan. The provision apparently has not been construed by the courts. OPM interprets the provision as requiring the carrier's concurrence before contingency reserve funds may be used to extend benefits beyond those within the express terms of the Plan. OPM's interpretation of the provision is entitled to substantial deference, and will be upheld unless unreasonable. *See Filiberti v. Merit Sys. Protection Bd.*, 804 F.2d 1504, 1508 (9th Cir. 1986)

[4] We do not decide the nature or extent of OPM's authority under section 8909(b)(2). Consistent with its view that the carrier's concurrence was necessary, OPM never invoked

authority under the section to direct Postmasters to provide additional benefits. Appellant has not challenged OPM's interpretation of its authority under section 8909(b)(2), nor has he alleged that OPM had a duty to ensure that contingency reserve funds be used to provide him with increased benefits. OPM, in fact, was never named as a defendant in appellant's suit to obtain nursing care benefits.

Contrary to appellant's repeated assertions, the record indicates only that OPM unsuccessfully sought Postmasters' voluntary agreement to amend the 1984 contract. We find no legal or factual bases for appellant's claim that Postmasters or Prudential violated a binding OPM directive.

b) *Catastrophic Protection.*

[5] Appellant next contends that the Catastrophic Protection provision of the Plan ensures him unlimited private duty nursing care benefits. The provision, at page 20 of the Brochure, states:

> CATASTROPHIC PROTECTION
>
> Under the High Option, if, in a calendar year, the out-of-pocket expenses for coinsured eligible expenses exceed $1,000 for a person under Self Only ($2,000 per family under Self and Family) the Plan will pay 100% of the eligible expenses during the remainder of that calendar year.
>
> Expenses incurred for the treatment of mental, psychoneurotic and personality disorders are not included under the Catastrophic Protection Benefit.

[6] This provision requires Postmasters to pay 100% of eligible expenses (when out-of-pocket expenses exceed a certain amount) as opposed to 80% of such expenses it would pay in other situations. The provision does not, however, operate

independent of the $10,000 limitation on private nursing care.

[7] The operative language here is the phrase "eligible expenses." The eligible expenses for nursing care are set out immediately above the Catastrophic Protection provision:

> PRIVATE DUTY NURSING CARE BENEFIT
>
> Benefits for private duty nursing care by a professional registered nurse (R.N.), licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.) are limited to a maximum of $10,000 per person per calendar year.

Appellant's contention that the Catastrophic Protection provision requires Postmasters to provide unlimited private nursing care benefits renders meaningless the phrase "eligible expenses" and ignores the $10,000 limitation stated plainly on the same page of the Brochure and again on page 27. *See Garvey v. Prudential Ins. Co. of America*, 596 F. Supp. 1119, 1126 (E.D. Pa. 1984) (Catastrophic Protection provision is subject to the $10,000 limitation on benefits for private duty nursing care). We find no merit in appellant's alternative argument that the Brochure language is ambiguous and should be construed in his favor. *See Id.* at 1125-26.

4. *State Law Claims.*

The final issue before us concerns the extent to which FEHBA preempts state law. The district court granted summary judgment for appellees in *Hayes v. Prudential* on this issue on the ground that FEHBA's section 8902(m)(1) preempted appellant's state law claims.

This section reads:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or

> benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1). The policy underlying section 8902(m)(1) is to ensure uniformity in the administration of FEHBA benefits. *See* H.R. Rep. No. 282, 95th Cong., 1st Sess. 1, 4 (1977).

The parties advance differing views concerning the extent of federal preemption under FEHBA. Appellees contend that the preemption provision is extremely broad, while appellant characterizes the provision as one of "limited preemption" which precludes only those state claims that apply to the "benefit structure" of the plan. The courts are not in agreement on this question. *Compare Blue Cross & Blue Shield of Florida, Inc. v. Department of Banking and Fin.*, 791 F.2d 1501 (11th Cir. 1986)(Florida's Unclaimed Property Act preempted to the extent it conflicts with federal employee benefit plan); *Myers v. United States*, 767 F.2d 1072, 1074 (4th Cir. 1985) (state law which purports to allow recovery of additional benefits not contemplated by a federal insurance contract must be deemed inconsistent with and preempted by FEHBA); and *Tackitt v. Prudential Ins. Co.*, 758 F.2d 1572, 1575 (11th Cir. 1985)("the interpretation of health insurance contracts is controlled by federal, not state, law") *with Howard v. Group Hosp. Serv.*, 739 F.2d 1508, 1510-12 (10th Cir. 1984) (approving state law interpretation of FEHBA Plan provisions).

[8] Appellant contends that his state law claims[1] are not

[1]Appellant alleged the following state law causes of action: (1) breach of contract, (2) breach of the implied covenant of good faith and fair dealing, (3) breach of duties under Cal. Ins. Code § 790.03 (West 1982), (4) civil conspiracy to breach the implied covenant of good faith and fair dealing and to violate Cal. Ins. Code § 790.03 (West 1982), (5) common law fraud, and (6) breach of fiduciary duty.

preempted under section 8902(m)(1), because the claims relate to the manner in which Postmasters and Prudential *processed* his benefits, and not to the "nature or extent of coverage or benefits." No such distinction can be made. Tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract. *See Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 213-20 (1985) (state tort claim stemming from manner in which a Labor Management Relations Act insurance benefit claim was handled is not independent of insurance contract and therefore is preempted by federal law). Moreover, the claims "relate to" the plan under section 8902(m)(1) as long as they have a connection with or refer to the plan. *Blue Cross*, 791 F.2d at 1504. All appellants' state law claims refer to the plan, and therefore fall under the preemption clause.

[9] Because the state law claims invariably expand appellees' obligations under the terms of the Plan, the claims are inconsistent with the Plan and, hence, preempted under § 8902(m)(1). Our holding is supported by the Supreme Court's recent decision that the Employee Retirement Income Security Act (ERISA) preempts state common law tort and contract claims for benefits under an ERISA-regulated plan. *Pilot Life Ins. Co. v. Dedeaux*, 55 U.S.L.W. 4471 (U.S. Apr. 6, 1987)(No. 85-1043). ERISA's preemption clause is similar to section 8902(m)(1) of the FEHBA.[2] And the Court held that the state claims were preempted despite a saving clause, 29 U.S.C. § 1144(b)(2)(A), which has no counterpart in the FEHBA. Thus, we hold Hayes' state law claims are preempted by the FEHBA. We note that, to the extent the state law claims are predicated on an alleged obligation of appellees to provide benefits in excess of the $10,000 limit stated in the Plan, the claims are moot in light of our ruling that no such obligation existed.

[2]ERISA's preemption clause states that "the provisions of this subchapter . . . shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. § 1144(a).

IV. CONCLUSION

Appellant has brought an effective appeal from the summary judgment in *NLP v. OPM*. Postmasters lawfully reduced private duty nursing care benefits to $10.000 in the 1984 and 1985 Plans, and was not required by OPM or the Catastrophic Protection provision to provide appellant with benefits in excess of that amount. Appellant's state law claims are preempted under 5 U.S.C. § 8902(m)(1). The judgment of the district court is AFFIRMED.

APPENDIX "C"

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

FILED, JUL 21 1987
Cathy A. Catterson, Clerk
U.S. Court of Appeals

KIP HAYES,	)	CA Nos.
	)	85-5527
Plaintiff-Appellant,	)	85-5528
	)	
vs.	)	DC Nos.
	)	
PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, et al.,	)	CV-84-1245-LCN
	)	CV-84-0341-LCN
	)	
	)	ORDER
	)	
Defendants-Appellees.	)	

Before: BROWNING, WIGGINS and BRUNETTI, Circuit Judges.

Appellant's petition for rehearing is denied.

APPENDIX "D"

Federal Employees Health Benefits Act ("FEHBA") 5 U.S.C.

§ 8901. Definitions

For the purpose of this chapter--

(1) "employee" means--

(A) an employee as defined by section 2105 of this title;

(B) a Member of Congress as defined by section 2106 of this title;

(C) a Congressional employee as defined by section 2107 of this title;

(D) the President;

(E) an individual employed by the government of the District of Columbia;

(F) an individual employed by Gallaudet College; and

(G) an individual employed by a county committee established under section 590h(b) of title 16;

but does not include--

(i) an employee of a corporation supervised by the Farm Credit Administration if private interests elect or appoint a member of the board of directors;

(ii) an individual who is not a citizen or national of the United States and whose permanent duty station is outside the United States, unless the individual was an employee for the purpose of this chapter on September 30, 1979, by reason of service in an Executive agency, the United States Postal Service, or the Smithsonian

Institution in the area which was then known as the Canal Zone;

(iii) an employee of the Tennessee Valley Authority; or

(iv) an employee excluded by regulation of the Office of Personnel Management under section 8913(b) of this title;

(2) "Government" means the Government of the United States and the government of the District of Columbia;

(3) "annuitant" means--

(A) an employee who retires on an immediate annuity under subchapter III of chapter 83 of this title or another retirement system for employees of the Government, after 5 or more years of service or for disability;

(B) a member of a family who receives an immediate annuity as the survivor of an employee or of a retired employee described by subparagraph (A) of this paragraph;

(C) an employee who receives monthly compensation under subchapter I of chapter 81 of this title and who is determined by the Secretary of Labor to be unable to return to duty; and

(D) a member of a family who receives monthly compensation under subchapter I of chapter 81 of this title as the surviving beneficiary of--

(i) an employee who dies as a result of injury or illness

compensable under that subchapter; or

(ii) a former employee who is separated after having completed 5 or more years of service and who dies while receiving monthly compensation under that subchapter and who has been held by the Secretary to have been unable to return to duty;

(4) "service", as used by paragraph (3) of this section, means service which is creditable under subchapter III of chapter 83 of this title;

(5) "member of family" means the spouse of an employee or annuitant and an unmarried dependent child under 22 years of age, including--

(A) an adopted child or recognized natural child; and

(B) a stepchild, or foster child but only if the child lives with the employee or annuitant in a regular parent-child relationship; or such an unmarried dependent child regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22;

(6) "health benefits plan" means a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services;

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization;

(8) "employee organization" means an association or other organization of employees which is national in scope, or in which membership is open to all

employees of a Government agency who are eligible to enroll in a health benefits plan under this chapter, and which, after December 31, 1978, and before January 1, 1980, applied to the Office for approval of a plan provided under section 8903(3) of this title;

(9) "dependent", in the case of any child, means that the employee or annuitant involved is either living with or contributing to the support of such child, as determined in accordance with such regulations as the Office shall prescribe; and

(10) "former spouse" means a former spouse of an employee, former employee, or annuitant--

(A) who has not remarried before age 55 after the marriage to the

employee, former employee, or annuitant was dissolved,

(B) who was enrolled in an approved health benefits plan under this chapter as a family member at any time during the 18-month period before the date of the dissolution of the marriage to the employee, former employee, or annuitant, and

(C)(i) who is receiving any portion of an annuity under section 8345(j) of this title or a survivor annuity under section 8341(h) of this title (or benefits similar to either of the aforementioned annuity benefits under a retirement system for Government employees other than the Civil Service Retirement System),

(ii) as to whom a court order or decree referred to in section 8341(h) or 8345(j) of this title (or similar provision of law under any such retirement system other than the Civil Service Retirement System) has been issued, or for whom an election has been made under section 8339(j)(3) of this title (or similar provision of law), or

(iii) who is otherwise entitled to an annuity or any portion of an annuity as a former spouse under a retirement system for Government employees, except that such term shall not include any such unremarried former spouse of a former employee whose marriage was

dissolved after the former employee's separation from the service (other than by retirement).

§ 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 of this title, without regard to section 5 of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall require the carrier--

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 of this title and for carriers offering

the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, or former spouse whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, or former spouse who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier

except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term,

based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, or former spouse is entitled thereto under the terms of the contract.

(k) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist or optometrist, licensed or certified as such under Federal or State law, as applicable, an employee, annuitant, family member, or former spouse covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist or optometrist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed. The provisions of this subsection shall not apply to group practice prepayment plans.

(l) The Office shall contract under this chapter for a plan described in section 8903(4) of this title which any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, "qualified health maintenance carrier" means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d)).

(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any

regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an

individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

§ 8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) Service benefit plan.--One Government-wide plan, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, or former spouses or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, or former spouse.

(2) Indemnity benefit plan.--One Government-wide plan, offering two levels of benefits, under which a carrier agrees to pay certain sums

of money, not in excess of the actual expenses incurred, for benefits of the types described by section 8904(2) of this title.

(3) Employee organization plans.--Employee organization plans which offer benefits of the types referred to by section 8904(3) of this title, which are sponsored or underwritten, and are administered, in whole or substantial part, by employee organizations, which are available only to individuals, and members of their families, who at the time of enrollment are members of the organization.

(4) Comprehensive medical plans.--

(A) Group-practice prepayment plans.--Group-practice prepayment

plans which offer health benefits of the types referred to by section 8904(4) of this title, in whole or in substantial part on a prepaid basis, with professional services thereunder provided by physicians practicing as a group in a common center or centers. The group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

(B) Individual-practice prepayment plans.--Individual-practice prepayment plans which offer health services in whole or substantial part on a prepaid

basis, with professional services thereunder provided by individual physicians who agree, under certain conditions approved by the Office, to accept the payments provided by the plans as full payment for covered services given by them including, in addition to in-hospital services, general care given in their offices and the patients' homes, out-of-hospital diagnostic procedures, and preventive care, and which plans are offered by organizations which have successfully operated similar plans before approval by the Office of the plan in which employees may enroll.

§ 8904. Types of benefits

The benefits to be provided under plans described by section 8903 of this title may be of the following types:

(1) Service benefit plan.--

(A) Hospital benefits.

(B) Surgical benefits.

(C) In-hospital medical benefits.

(D) Ambulatory patient benefits.

(E) Supplemental benefits.

(F) Obstetrical benefits.

(2) Indemnity benefit plans.--

(A) Hospital care.

(B) Surgical care and treatment.

(C) Medical care and treatment.

(D) Obstetrical benefits.

(E) Prescribed drugs, medicines, and prosthetic devices.

(F) Other medical supplies and services.

(3) Employee organization plans.--Benefits of the types named under paragraph (1) or (2) of this section or both.

(4) Comprehensive medical plans.--Benefits of the types named under paragraph (1) or (2) of this section or both.

All plans contracted for under paragraphs (1) and (2) of this section shall include benefits both for costs

associated with care in a general hospital and for other health services of a catastrophic nature. Pub.L. 89-554, Sept 6, 1966 80 Stat.603.

§ 8905. Election of coverage

(a) An employee may enroll in an approved health benefits plan described by section 8903 of this title either as an individual or for self and family.

(b) An annuitant who at the time he becomes an annuitant was enrolled in a health benefits plan under this chapter--

(1) as an employee for a period of not less than--

(A) the 5 years of service immediately before retirement;

(B) The full period or periods of service between the last day of the first period, as prescribed by regulations of the Office of Personnel Management in which he is eligible to enroll in the plan and the date on which he becomes an annuitant; or

(C) the full period or periods of service beginning with the enrollment which became effective before January 1, 1965, and ending with the date on which he becomes an annuitant;

whichever is shortest; or

(2) as a member of the family of an employee or annuitant;

may continue his enrollment under the

conditions of eligibility prescribed by regulations of the Office.

(c)(1) A former spouse may--

(A) within 60 days after the dissolution of the marriage, or

(B) in the case of a former spouse of a former employee whose marriage was dissolved after the employee's retirement, within 60 days after the dissolution of the marriage or, if later, within 60 days after an election is made under section 8339(j)(3) of this title for such former spouse by the retired employee,

enroll in an approved health benefits plan described by section 8903 of this title as an individual or for self and

family as provided in paragraph (2) of this subsection, subject to an agreement to pay the full subscription charge of the enrollment, including the amounts determined by the Office to be necessary for administration and reserves pursuant to section 8909(b) of this title. The former spouse shall submit an enrollment application and make premium payments to the agency which, at the time of divorce or annulment, employed the employee to whom the former spouse was married or, in the case of a former spouse who is receiving annuity payments under section 8341(h) or 8345(j) of this

title, to the Office of Personnel Management.

(2) Coverage for self and family under this subsection shall be limited to--

(A) the former spouse; and

(B) unmarried dependent natural or adopted children of the former spouse and the employee who are--

(i) under 22 years of age; or

(ii) incapable of self-support because of mental or physical disability which existed before age 22.

(d) If an employee has a spouse who is an employee, either spouse, but not

both, may enroll for self and family, or each spouse may enroll as an individual. However, an individual may not be enrolled both as an employee or annuitant and as a member of the family.

(e) An employee, annuitant, or former spouse enrolled in a health benefits plan under this chapter may change his coverage or that of himself and members of his family by an application filed within 60 days after a change in family status or at other times and under conditions prescribed by regulations of the Office.

(f) An employee, annuitant, or former spouse may transfer his enrollment from a health benefits plan described by

section 8903 of this title to another plan described by that section at the times and under the conditions prescribed by regulations of the Office.

§ 8906. Contributions

(a) The Office of Personnel Management shall determine the average of the subscription charges in effect on the beginning date of each contract year with respect to self alone or self and family enrollments under this chapter, as applicable, for the highest level of benefits offered by--

(1) the service benefit plan;

(2) the indemnity benefit plan;

(3) the two employee organization plans with the largest number of

enrollments, as determined by the Office; and

(4) the two comprehensive medical plans with the largest number of enrollments, as determined by the Office.

(b)(1) Except as provided by paragraphs (2) and (3) of this subsection, the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 60 percent of the average subscription charge determined under subsection (a) of this section. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment

begins on the first day of the first period of each year for which an annuity payment is made.

(2) The biweekly Government contribution for an employee or annuitant enrolled in a plan under this chapter shall not exceed 75 percent of the subscription charge.

(3) In the case of an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title), the biweekly Government contribution shall be equal to the percentage which bears the same ratio to the percentage determined under this subsection (without regard to this paragraph) as the average number of hours of such employee's regularly scheduled workweek

bears to the average number of hours in the regularly scheduled workweek of an employee serving in a comparable position on a full-time career basis (as determined under regulations prescribed by the Office)

(c) There shall be withheld from the pay of each enrolled employee and the annuity of each enrolled annuitant and there shall be contributed by the Government, amounts, in the same ratio as the contributions of the employee or annuitant and the Government under subsection (b) of this section, which are necessary for the administrative costs and the reserves provided for by section 8909(b) of this title.

(d) the amount necessary to pay the total charge for enrollment, after the

Government contribution is deducted, shall be withheld from the pay of each enrolled employee and from the annuity of each enrolled annuitant. The withholding for an annuitant shall be the same as that for an employee enrolled in the same health benefits plan and level of benefits.

(e)(1) An employee enrolled in a health benefits plan under this chapter who is placed in a leave without pay status may have his coverage and the coverage of members of his family continued under the plan for not to exceed 1 year under regulations prescribed by the Office. The regulations may provide for the waiving of contributions by the employee and the Government.

(2) an employee who enters on approved leave without pay to serve as a full-time officer or employee of an organization composed primarily of employees as defined by section 8901 of this title, within 60 days after entering on that leave without pay, may file with his employing agency an election to continue his health benefits enrollment and arrange to pay currently into the Employees Health Benefits Fund, through his employing agency, both employee and agency contributions from the beginning of leave without pay. The employing agency shall forward the enrollment charges so paid to the Fund. If the employee does not so elect, his enrollment will continue during nonpay status and end as provided by paragraph

(1) of this subsection and implementing regulations.

(f) The Government contributions for health benefits for an employee shall be paid--

(1) in the case of employees generally, from the appropriation or fund which is used to pay the employee;

(2) in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment;

(3) in the case of an employee of the legislative branch who is paid by the Clerk of the House of Representatives, from the contingent fund of the House; and

(4) in the case of an employee in a leave without pay status, from the appropriation or fund which would be used to pay the employee if he were in a pay status.

(g) The Government contributions authorized by this section for health benefits for an annuitant shall be paid from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

(h) The Office shall provide for conversion of biweekly rates of contribution specified by this section to rates for employees and annuitants paid on other than a biweekly basis, and for this purpose may provide for the

adjustment of the converted rate to the nearest cent.

§ 8907. Information to individuals eligible to enroll

(a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Office after consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans described by section 8903 of this title.

(b) Each enrollee in a health benefits plan shall be issued an appropriate document setting forth or summarizing the--

(1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder;

(2) procedure for obtaining benefits; and

(3) principal provisions of the plan affecting the enrollee and any eligible family members.

§ 8908. Coverage of restored employees and survivor annuitants

(a) An employee enrolled in a health benefits plan under this chapter who is removed or suspended without pay and later reinstated or restored to duty on the ground that the removal or suspension was unjustified or

unwarranted may, at his option, enroll as a new employee or have his coverage restored, with appropriate adjustments made in contributions and claims, to the same extent and effect as though the removal or suspension had not taken place.

(b) A surviving spouse whose survivor annuity under this title was terminated because of remarriage and is later restored may, under such regulations as the Office of Personnel Management may prescribe, enroll in a health benefits plan described by section 8903 of this title if such spouse was covered by any such plan immediately before such annuity was terminated.

§ 8909. Employees Health Benefits Fund

(a) There is in the Treasury of the United States an Employees Health Benefits Fund which is administered by the Office of Personnel Management. The contributions of enrollees and the Government described by section 8906 of this title shall be paid into the Fund. The Fund is available--

(1) without fiscal year limitation for all payments to approved health benefits plans; and

(2) to pay expenses for administering this chapter within the limitations that may be specified annually by Congress.

(b) Portions of the contributions made by enrollees and the Government shall be regularly set aside in the Fund as follows:

(1) a percentage, not to exceed 1 percent of all contributions, determined by the Office to be reasonably adequate to pay the administrative expenses made available by subsection (a) of this section.

(2) For each health benefits plan, a percentage, not to exceed 3 percent of the contributions toward the plan, determined by the Office to be reasonably adequate to provide a contingency reserve.

The Office, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves of the plans then under contract with the Office. When funds are so transferred, each contingency reserve shall be credited in proportion to the total amount of the subscription charges paid and accrued to the plan for the contract term immediately before the contract term in which the transfer is made. The income derived from dividends, rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future rates, or may be applied to reduce the contributions of employees

and the Government to, or to increase the benefits provided by, the plan from which the reserves are derived, as the Office from time to time shall determine.

(c) The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations become a part of the Fund.

(d) When the assets, liabilities, and membership of employee organizations sponsoring or underwriting plans approved under section 8903(3) of this title are merged, the assets (including contingency reserves) and liabilities of

the plans sponsored or underwritten by the merged organizations shall be transferred at the beginning of the contract term next following the date of the merger to the plan sponsored or underwritten by the successor organization. Each employee, annuitant, or former spouse affected by a merger shall be transferred to the plan sponsored or underwritten by the successor organization unless he enrolls in another plan under this chapter.

(e) Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans

continuing under this chapter for the contract term following that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

§ 8910. Studies, reports, and audits

(a) The Office of Personnel Management shall make a continuing study of the operation and administration of this chapter, including surveys and reports on health benefits plans available to employees and on the experience of the plans.

(b) Each contract entered into under section 8902 of this title shall contain provisions requiring carriers to--

(1) furnish such reasonable reports as the Office determines to be necessary to enable it to carry out its functions under this chapter; and

(2) permit the Office and representatives of the General Accounting Office to examine records of the carriers as may be necessary to carry out the purposes of this chapter.

(c) Each Government agency shall keep such records, make such certifications, and furnish the Office with such information and reports as may be

necessary to enable the Office to carry out its functions under this chapter.

§ 8911. Advisory committee

The Director of the Office of Personnel Management shall appoint a committee composed of five members, who serve without pay, to advise the Office regarding matters of concern to employees under this chapter. Each member of the committee shall be an employee enrolled under this chapter or an elected official of an employee organization.

§ 8912. Jurisdiction of courts

The district courts of the United States have original jurisdiction, concurrent with the United States Claims Court, of a civil action or claim against the United States founded on this chapter.

§ 8913. Regulations

(a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.

(b) The regulations of the Office may prescribe the time at which and the manner and conditions under which an employee is eligible to enroll in an approved health benefits plan described

by section 8903 of this title. The regulations may exclude an employee on the basis of the nature and type of his employment or conditions pertaining to it, such as short-term appointment, seasonal or intermittent employment, and employment of like nature. The Office may not exclude--

(1) an employee or group of employees solely on the basis of the hazardous nature of employment;

(2) a teacher in the employ of the Board of Education of the District of Columbia, whose pay is fixed by section 1501 of title 31, District of Columbia Code, on the basis of the fact that the teacher is serving under a temporary appointment if the teacher has been

so employed by the Board for a period or periods totalling not less than two school years; or

(3) an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title).

(c) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees, annuitants, members of their families, and former spouses under health benefits plans. The regulations may permit the coverage to continue, exclusive of the temporary extension of coverage described by section 8902(g) of this title, until the end of the pay period in which an employee is separated from the service, or until the end of the

month in which an annuitant or former spouse ceases to be entitled to annuity, and in case of the death of an employee or annuitant, may permit a temporary extension of the coverage of members of his family for not to exceed 90 days.

(d) The Secretary of Agriculture shall prescribe regulations to effect the application and operation of this chapter to an individual named by section 8901(1)(H) of this title.